

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5366PCA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/14/2011
NAME OF PROVIDER OR SUPPLIER ABSOLUTE PERSONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5527 S RAINBOW STE C LAS VEGAS, NV 89119		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
P 000	<p>Initial Comments</p> <p>This findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>This Statement of Deficiencies was generated as a result of the Focused State Relicensure survey conducted in your agency on 2/4/2011 to 2/14/2011. The Focused State Relicensure survey was conducted at your agency by authority of Chapter 449, Personal Care Agencies.</p> <p>The patient census was 35. Six client records were reviewed. Three client telephone interviews were conducted. Five employee files were reviewed.</p> <p>Reviewed the following documentation: Complaint/Incident logs; Agency Policies and Procedures; Infection Control Policies, Procedures, and Training Materials; Records/Documentation of PCA Training; New Client Packet and Agency Brochure; and Supervisor's Visits to Client's Homes and Evaluations of Caregivers .</p> <p>No regulatory deficiencies were identified. Please keep a copy of this statement for your records. No further action is required.</p>	P 000			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE